Chapter V

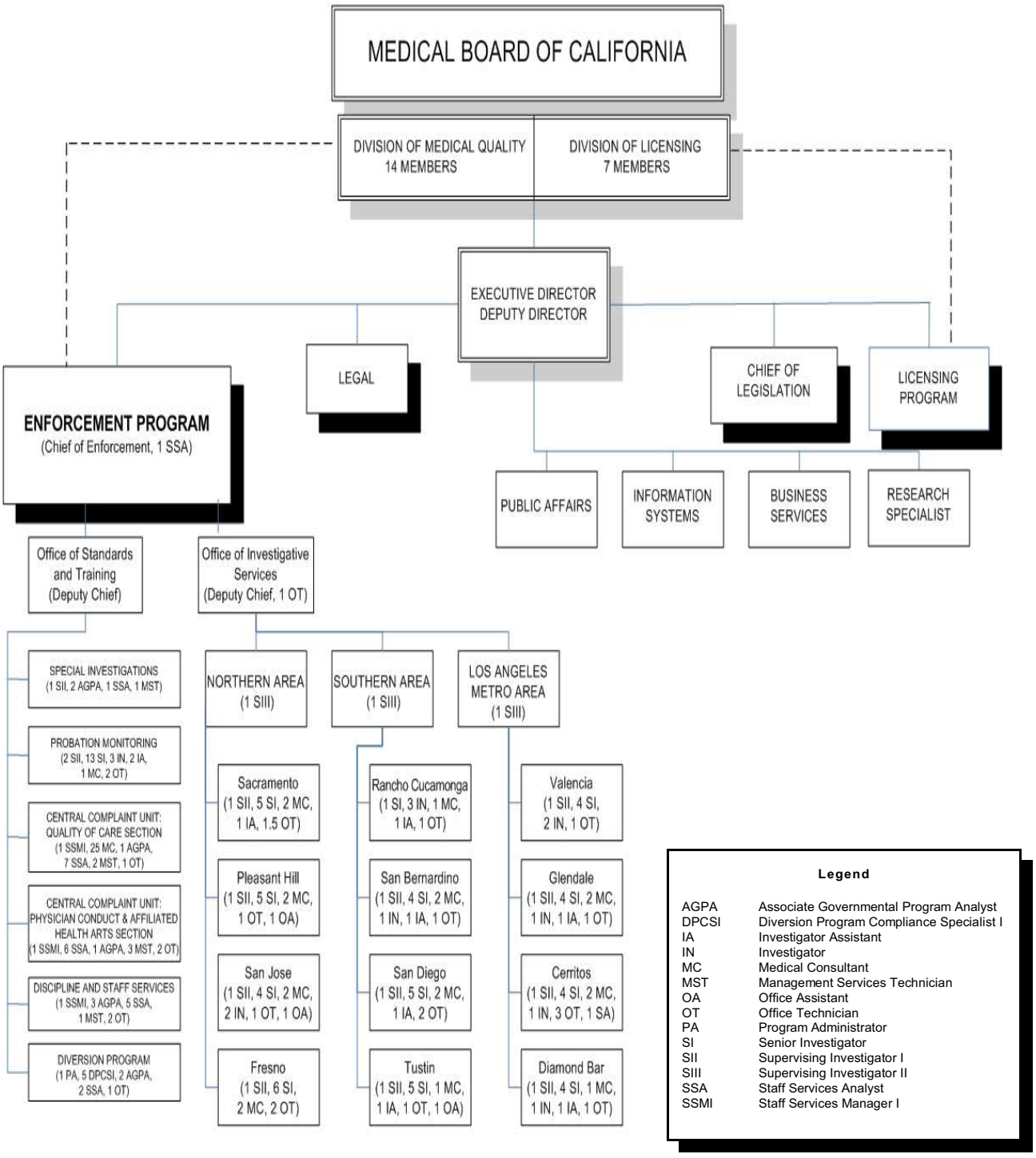
MBC'S ENFORCEMENT PROGRAM: GENERAL DESCRIPTION AND THRESHOLD CONCERNS

A. General Description of Functions

The Medical Board's enforcement program is complex, fragmented, and expensive. Individuals from three separate agencies participate in its proceedings, and it cost the Board $28.2 million in 2003–04. Although its various components will be described and critiqued in detail in succeeding chapters, a brief description of the various steps of the process is provided here — along with an enforcement program organizational chart, a flowchart of the pathway of a complaint through the process, detailed data to give the reader a sense of the complexity of the process and the number of complaints handled by the various participants, and a discussion of several Monitor concerns that cut across the entirety of the enforcement program.

Central Complaint Unit. Prior to 1990, complaints and reports of physician misconduct were received by complaint intake personnel located at local district offices of the Medical Board. When that decentralized complaint intake system proved unsatisfactory, MBC centralized its complaint intake function in the Central Complaint Unit (CCU) in Sacramento. As reflected in Exhibit V-A below, CCU is presently divided into two sections — the Quality of Care Section (which handles complaints related to diagnosis and/or treatment provided by a physician to a patient in the context of the physician/patient relationship) and the Physician Conduct Section (which handles all other complaints). In most quality of care cases, CCU procures the medical records of the complainant and requests a response or explanation from the subject physician. The medical records and explanation are reviewed by a CCU "medical consultant" (a physician practicing in a similar specialty as the complained-of physician) who recommends whether the matter warrants formal investigation. In non-quality of care cases, CCU may procure medical records and forward them for medical consultant review (if applicable), and/or request a response or explanation from the subject physician; CCU then processes the case as appropriate depending on the type of case and sufficiency of the evidence. Cases that survive CCU screening are referred for formal investigation.

Ex. V-A. MBC Enforcement Program Organizational Chart
(October 2004)



Source: Medical Board of California

Field Investigations. MBC maintains twelve field offices (called "district offices") staffed by professional peace officer investigators and supervising investigators. A case that has survived CCU screening is referred "to the field" in the geographical area where the subject physician practices and is assigned to one of MBC's investigators. That investigator — assisted by district office "medical consultants" (again, licensed physicians), the supervising investigator, and a deputy attorney general from the Health Quality Enforcement (HQE) Section of the Attorney General's Office — develops an investigative plan appropriate to the type of case and conducts the investigation. Investigations typically include the gathering of additional medical records; interviews with the complainant(s), witnesses, and the subject physician; and — in quality of care cases — review of the entire investigative report and the evidence by an "expert reviewer" (again, a licensed physician in the same or similar specialty as the complained-of physician) who opines on the standards of care applicable to the particular matter, whether the subject physician's conduct fell below those standards, in what way(s), and to what degree. If the investigative report and the expert review indicate that the subject physician has committed a serious and disciplinable violation, the matter is referred to HQE for the drafting of an accusation against the physician's license, and/or (in appropriate cases) to local prosecutors for the filing of criminal charges.

Administrative Prosecutions. Once a Medical Board investigator completes an investigative report recommending the filing of an accusation in a given case and that recommendation (often supported by expert testimony) is approved, the matter is transferred to HQE where it is assigned to a deputy attorney general (DAG). The DAG reviews the investigative file and determines whether it is complete and sufficient to prove a disciplinary violation. If so, the DAG prepares an "accusation" (a formal written statement of charges)[53] and returns it to the Medical Board's executive director for approval.[54] The accusation is deemed "filed" when the executive director signs it. The accusation is then served on the subject physician, who is now called the "respondent."[55]

The filing of the accusation triggers the adjudication process governed by the Administrative Procedure Act (APA),[56] which is designed to ensure that an accused licensee is afforded appropriate

[53] Gov't Code § 11503.

[54] In less serious cases not warranting license revocation, suspension, or probation, MBC may issue a citation and fine, Bus. & Prof. Code § 125.9, or opt to offer the physician a "public letter of reprimand" in lieu of filing or prosecuting an accusation. *Id*. at § 2233.

[55] Gov't Code § 11500(c).

[56] *Id*. at § 11370 *et seq*.; *see also* Bus. & Prof. Code § 2230(a).

procedural due process before his or her property right (the license) is taken.[57] According to caselaw interpreting the APA, the agency is the moving party, has the burden of proof, and must prove a disciplinary violation by "clear and convincing proof to a reasonable certainty."[58]

Once the accusation is filed, the respondent may file a notice of defense.[59] If such a notice is filed, MBC transfers the case file back to the DAG, who secures a hearing date from the Office of Administrative Hearings (see below). Thereafter, the parties engage in limited discovery[60] and — barring a settlement that is approved by MBC enforcement staff and the Division of Medical Quality — present their respective cases at a public evidentiary hearing presided over by an administrative law judge (ALJ) from the Office of Administrative Hearings. At the hearing and throughout any post-hearing proceedings, the HQE DAG represents the Medical Board; the respondent may be represented by private counsel at his/her own expense.

Office of Administrative Hearings' Medical Quality Hearing Panel. The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state agency adjudicative hearings in a variety of areas. As noted in Chapter IV, a special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH in 1990's SB 2375 and refined in 1993's SB 916; ALJs appointed to the MQHP are permitted to specialize in physician discipline matters.[61] The law requires an MQHP ALJ to preside over MBC evidentiary hearings.[62]

During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument.[63] Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline.[64] At the Board's request, the ALJ may also recommend that the licensee pay "cost recovery" to reimburse the Board for its investigative and enforcement costs incurred up to the first

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[57] *See*, *e.g.*, Gov't Code § 11425.10.

[58] *See*, *e.g.*, *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

[59] Gov't Code § 11506.

[60] *Id*. at 11507.6.

[61] *Id*. at § 11371.

[62] *Id*. at § 11372.

[63] *Id*. at § 11513.

[64] *Id*. at § 11425.50.

day of the evidentiary hearing.[65] The ALJ's ruling is a "proposed decision"[66] which is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision (see below).

In filing charges and recommending discipline, the DAG and the ALJ are guided by a set of "disciplinary guidelines" approved by DMQ; these guidelines set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[67]

Division of Medical Quality Review. Following completion of the evidentiary hearing, the ALJ's proposed decision is transmitted to MBC headquarters for review by DMQ. For purposes of reviewing ALJ proposed decisions, the fourteen-member DMQ divides into two seven-member panels (Panel A and Panel B); a proposed decision is assigned to one of the panels for review.[68] Within 90 days of receipt of the proposed decision, the assigned DMQ panel must review the ALJ's ruling and decide whether to "adopt" it as the final agency decision for purposes of judicial review, or "nonadopt" it because it is defective or inappropriate in some way.[69] If the panel nonadopts the ALJ's proposed decision because it believes the penalty should be more harsh than that recommended by the ALJ, the panel must order a record of the evidentiary hearing, make it available to both parties,[70] and afford the parties an opportunity for oral argument before the panel prior to deciding the case.[71] In imposing disciplinary sanctions, the DMQ panel must consider the Division's "disciplinary guidelines," which set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[72]

Judicial Review of DMQ's Decision. A physician whose license has been disciplined by DMQ may seek judicial review of the Division's decision by filing a petition for writ of mandate in

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[65] Bus. & Prof. Code § 125.3.

[66] Gov't Code § 11517.

[67] Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board's disciplinary guidelines.

[68] Bus. & Prof. Code § 2230(b).

[69] *Id*. at § 2335(c)(3).

[70] Gov't Code § 11517(c)(2)(E).

[71] Bus. & Prof. Code § 2335(c)(4).

[72] *See supra* note 67.

superior court under Code of Civil Procedure section 1094.5.[73] Generally, the focus of the court's review is to determine whether DMQ's factual findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency's discretion or constitutes an abuse of that discretion.[74] Following its review, the superior court may affirm DMQ's decision, or may reverse and/or vacate it and remand it to DMQ for further proceedings.

Either side may challenge the superior court's decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal.[75] If the court believes the petition is meritorious, it will grant an alternative writ, order full briefing, entertain oral argument, and issue a written decision. If the court believes the petition is nonmeritorious, it may summarily deny the writ, thus obviating the need for oral argument and a written opinion in the matter.

If the appellate court affirms the superior court's decision, either party may petition the California Supreme Court to review the case. Such review is entirely discretionary and is rarely attempted or granted.

MBC Enforcement Program Flowchart. Exhibit V-B below presents the pathway of a complaint or report of physician misconduct through the MBC enforcement program described above. Additionally, it presents MBC's fiscal year 2003–04 "throughput" — the number of cases that entered each step and their overall disposition.

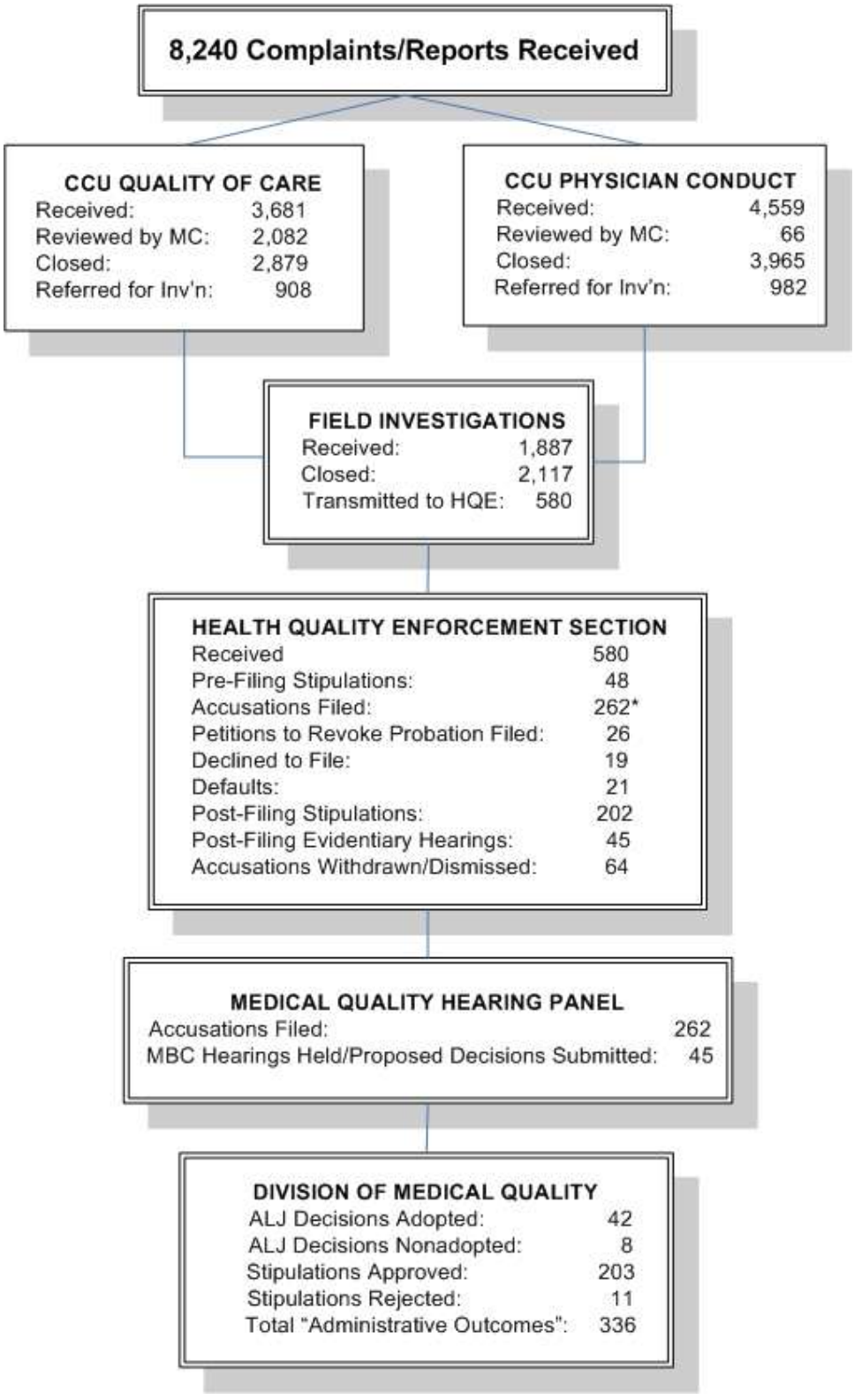
Exhibit V-C below presents MBC enforcement data from 1991–92 (the year in which HQE was created) to the present. The data in this "master" Enforcement Program Statistical Profile will be analyzed, explained, and referred to frequently throughout the remainder of this Initial Report.

[73] Gov't Code § 11523.

[74] Civ. Proc. Code § 1094.5(b).

[75] Bus. & Prof. Code § 2337.

Ex. V-B. 2003–04 MBC Enforcement Program Throughput



*Multiple cases against the same physician are frequently combined into one accusation.

Source: Medical Board of California

Ex. V-C. Enforcement Program Statistical Profile
Physicians and Surgeons

Workload Measure		3-Year Averages 1991/92 through 1993/94	3-Year Averages 1994/95 through 1996/97	3-Year Averages 1994/95 through 1999/00	2000/01	2001/02	2002/03	2003/04
Active Licensees		102,680	103,266	106,835	109,289	112,273	115,354	117,806
Complaint Intake and Review	Complaints Received - B&P Code, Section 800 and 2240(a) Reports	1,010	1,191	1,441	1,538	1,454	1,385	1,240
	Complaints Received - Govt. & Law Enforcement	NA	1,844	1,855	1,953	1,996	1,737	1,593
	Complaints Received - Profession	NA	153	270	279	264	295	283
	Complaints Received - Public & Other	5,730	3,800	4,046	4,450	4,845	5,478	5,124
	Total Complaints Received (Excl. NOI and NPDB Reports)	6,740	6,988	7,612	8,220	8,559	8,895	8,240
	Complaints Closed Without Investigation	4,289	5,616	5,608	5,011	6,818	6,072	6,837
	Complaints Referred for Investigation, Including Change of Address Citations	2,608	2,026	2,125	2,320	2,608	2,138	1,887
	Total Complaints Closed/Referred for Investigation	6,897	7,642	7,734	7,331	9,426	8,210	8,724
	NOI Reports Closed	47	1,934	2,282	2,247	2,244	2,377	2,148
	NPDB Reports Closed	114	2,106	776	432	415	284	273
	Pending Complaints (End of Period)	3,397	1,555	1,279	2,229	1,403	2,019	1,566
Investigation	Investigations Closed or Referred, Including Change of Address Citations	2,066	2,095	2,304	2,374	2,449	2,361	2,117
	Referrals to District Attorney (DA) Offices	80	63	70	58	82	47	37
	Referrals to Attorney General's Office (AGO)	460	497	595	510	589	494	580
	Pending Investigations (End of Period, Excluding Legal Actions)	2,303	1,824	1,406	1,346	1,531	1,251	1,060
	Pending Investigations Per Investigator (Including AHLP Cases)	33	26	21	18	20	21	18
Probation (Incl. AHLP)	Active, In-State Cases (End of Period)	475	569	500	503	498	516	547
	Cases Per Investigator	53	63	42	39	36	40	46
	Pending Investigations (End of Period)	69	94	13	35	78	73	43
	Pending Legal Action Cases (End of Period)	77	18	37	46	53	39	42
	Pending Investigations & Legal Actions Per Investigator	17	12	1	3	6	6	4
Legal Actions	TROs/ISOs Ordered	25	28	28	17	26	12	22
	Accusations Filed	282	289	327	238	329	258	262
	Petitions to Revoke Probation Filed	10	15	31	18	21	18	26
	Accusations Withdrawn/Dismissed	33	75	88	54	48	45	64
	Pending Legal Actions (End of Period; Including AHLP; Excl. Probation)	584	572	496	547	655	608	494
	Pending Legal Actions Per Investigator (Including AHLP Cases)	23	8	7	7	9	10	8
Disciplinary Actions	Citations and Administrative Fines Issued	NA	141	290	513	520	532	423
	Revocation	51	59	50	39	38	40	37
	Surrender	29	67	77	49	47	67	65
	Suspension	0	1	2	5	6	4	2
	Suspension and Probation	29	30	16	16	19	27	31
	Probation Only	51	127	109	91	69	87	98
	Public Reprimand	NA	44	50	50	52	58	51
	Total, Excluding Citations	162	328	304	250	231	283	284
Diversion Program	Accepted Into Program	64	58	63	70	52	47	53
	Successful Completions	53	40	33	46	46	38	37
	Terminations and Withdrawals	22	18	18	7	10	10	23
	Active, In-State Participants (End of Period)	226	213	256	273	269	262	258
	Pending Applicants (End of Period)	24	49	48	41	53	43	29
	Out-of-State Monitored Licensees (End of Period)	0	12	17	15	11	15	17
	Total Monitored at End of Period	250	274	321	329	333	320	304
B&P Mandated Reports	Sections 801/801.1 - Malpractice Reporting by Insurers	746	894	1,024	921	872	872	787
	Sections 801(e)/802/803.2 - Malpractice Self-Reporting	79	130	232	391	313	281	228
	Section 803 - Malpractice Reporting by Courts	10	21	26	25	30	16	3
	Section 802.5 - Coroners	16	9	32	33	38	24	18
	Sections 802.1/803.5 - Criminal Charges and Convictions	0	18	26	37	38	24	33
	Section 805 - Health Care Facilities (Competence)	159	119	101	124	151	162	157
	Section 2240(a) - Self-Reported Surgical Death/Complications	0	0	0	7	12	6	14
	Total B&P Mandated Reports	1,010	1,191	1,441	1,538	1,454	1,385	1,240

Sources: Medical Board of California Annual Reports, California Department of Consumer Affairs Annual Statistical Profiles, and MBC Complaint Tracking System data.

B. Threshold Concerns of the MBC Enforcement Monitor

Following is a description of concerns about MBC's enforcement program that cut across all of its components and the program as a whole.

1. Overall, the enforcement process simply takes too long to protect the public.

In Exhibit V-D below, we recap the actual, total, average length of time consumed by the entire process for a serious quality of care complaint — the type of complaint targeted by SB 1950 (Figueroa) — during fiscal year 2003–04:

EX. V-D. FY 2003-04 Average Quality of Care Complaint Processing Time

CCU processing	79 days[76]
Field investigations (including expert review)	261 days[77]
HQE prior to accusation filing	107 days[78]
HQE post-filing/ OAH hearing and proposed decision/ DMQ review and decision	513 days[79]
TOTAL TIME TO FINAL DMQ DECISION	**960 days = 2.63 years**

Source: Medical Board of California

That 2.63 years is an average; many cases take much longer. It does not account for the serious delays often occasioned by the section 2220.08 "specialty reviewer" requirement in CCU.[80] It does not account for excessive delays in accusation filing and prosecution by HQE's Los Angeles office, which files about 60% of the accusations in the state and has been uniquely plagued with debilitating staffing losses.[81] And it also does not count the time consumed by judicial review if DMQ's decision is ultimately challenged by the respondent physician. Petitions for writ of mandate

[76] *See infra* Ch. VI.B.2.

[77] *See infra* Ex. VII-A and Ch. VII.B.1.

[78] *See infra* Ch. IX.A. and Ex. IX-B.

[79] Medical Board of California, *2003–04 Annual Report* at vi.

[80] *See infra* Ch. VI.B.3.

[81] *See infra* Ch. IX.A.

decided by superior courts in 2003–04 consumed an additional 409 days (1.12 years),[82] and in 47% of those cases, DMQ's disciplinary decision was stayed[83] — meaning the physician was free to continue practicing during judicial review. The total average time from the filing of a serious quality of care complaint to a judicially-reviewed disciplinary decision is thus 1,369 days, or 3.75 years.

The Monitor understands that MBC has no control over the court system. It also has no direct control over its resources and staffing, and — as described below — both have suffered in recent years. However, it does have direct control over its own complaint processing. HQE has direct control over its prosecution activities. The ensuing chapters break down the cycle time at each step of the process and identify steps that consume an excessive amount of time, such as medical records procurement, subject interviews, and expert reviews. With the support of the Legislature and Administration, MBC and HQE must target and attack these time-consuming steps once and for all.

2. MBC resources are inadequate.

In recent years, the Medical Board has suffered a devastating combination of blows to its funding and staffing, and excessive increases in the costs of doing business. These events are described below.

Outdated License Fee Structure. MBC is funded almost exclusively by physician licensing fees, and those fees were last adjusted to $600 biennially ($300 per year) in January 1994 — eleven (11) years ago. An outdated license fee structure means that MBC resources are inadequate to meet the Legislature's and the public's demand for service improvement. Service and work requirements associated with regulating each licensee have remained constant or increased since 1994, while the number of licensees and citizens using physician services has increased significantly. Under these circumstances, MBC has experienced a substantial reduction in inflation-adjusted per licensee funding, roughly equal to the 27.9% increase in the California Consumer Price Index in the past eleven years. If $300 was an appropriate license renewal fee in 1994, it is roughly 28% less appropriate today.

As described in Chapter IV, MBC determined that it needed a renewal fee increase to $700 biennially in 1995. Thereafter, it decided to delay a fee increase request in order to examine other parts of its budget and wring all possible efficiencies from its budget as a whole. By doing this, it was able to delay its fee increase request for three years. Instead of being rewarded for its efforts and its efficiency, however, MBC was penalized. Its attempts to secure an increase in the legislative cap on fees in 1998, 1999, and 2000 were met with strong CMA resistance and counteroffers that were

[82] *See infra* Ch. XII.B.

[83] *Id*.

unacceptable to MBC, and were ultimately abandoned. As a result, MBC's fees have not been increased in eleven years.

It is unclear why a profession should be permitted to control the level of resources used by its regulatory agency to police its ranks in the broader public interest.[84] Consumer advocates note that "renewal fees" — as with any industry-wide assessment — are predominantly passed on to consumers. As discussed in Chapter IV, the medical profession — in exchange for a cap on physician liability in medical malpractice lawsuits — agreed in 1975 to support a strengthened Medical Board enforcement program aimed at removing the dangerous physicians whose actions injure patients, create those lawsuits, and impose costs across the physician population in the form of higher malpractice premiums. The medical profession and the insurance industry still reap the benefit of that bargain: The $250,000 cap on noneconomic damages in medical malpractice lawsuits — the lowest cap in the nation — has not been lifted or adjusted since 1975. Today, the inflation-adjusted value of that $250,000 cap is $71,000.[85] A recent study of 257 plaintiff verdicts in malpractice trials from 1995 through 1999 revealed that the MICRA cap on noneconomic damages was imposed in 45% of the cases, reducing total liability in those cases from $421 million to $295 million.[86] The malpractice premiums paid by California physicians are the lowest in the nation.[87] However, the professional association representing physicians has repeatedly blocked fee increases requested by MBC to permit it to more effectively police the profession. Notwithstanding some merit to some of its objections to MBC enforcement practices, that successful and long-term opposition to necessary resources is arguably in breach of the agreement it made in 1975.

Impacts of the Hiring Freeze. Another series of events has plagued MBC, its staffing, and its resources. As discussed in Chapter IV, Governor Davis responded to the state's severe general fund budget crisis by issuing Executive Order D-48-01 on October 23, 2001, which imposed an

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[84] *But see supra* Ch. IV.F., n. 48 (Senate Business and Professions Committee's acknowledgment of the general policy that legislation increasing licensing fees will not be considered unless the affected trade association "signs off on the board's proposal, providing either endorsement or, at least, tacit agreement").

[85] Rachel Zimmerman and Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., October 8, 2004, at 1.

[86] Nicholas M. Pace, Daniela Golinelli, Laura Zakaras, Rand Institute for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA* (2004).

[87] The National Practitioner Data Bank surveyed mean and median malpractice premium payments in every state during 2000 and cumulatively between 1990 and 2000. During 2000, California physicians paid a median of $55,000 for medical malpractice insurance — the lowest in the nation and less than half the average median of $125,000. Cumulatively between 1990 and 2000, California physicians paid a median of $41,500 for malpractice insurance — again the lowest in the nation. Whether the MICRA cap, enhanced insurance rate regulation by the California Insurance Commissioner under 1988's Proposition 103, a combination of both, and/or other factors have resulted in California's low premiums is a matter of sharp debate, was not addressed in the Rand Institute study cited in footnote 86, and is beyond the scope of this report.

immediate statewide hiring freeze. According to the Order, "when business are faced with declining revenues and increasing expenditures, they take actions to reduce spending, and . . . the State of California must take similar actions without delay to ensure that it lives within its means." Thus, the Governor ordered that "[a]ll State agencies and departments, regardless of funding source, are prohibited from filling vacancies that would constitute a new hire to State Government." Shortly after taking office, Governor Schwarzenegger extended the freeze on November 20, 2003.

Thus, MBC — a special fund agency that receives no money from the general fund, whose revenue was not declining (except due to inflation), and whose salary savings due to the freeze would not assist the general fund deficit — was required to leave most vacant positions vacant, wherever they arose. At the end of fiscal years 2001–02 and 2002–03, the state then mechanically abolished many of the vacant positions that had accumulated, resulting in permanent staff position losses, and ordered a further 12% budget reduction in 2003–04.[88] As a result of these actions, MBC has lost a total of 44.8 staff positions since 2001, including 29 enforcement program positions (a 16.2% reduction since 2000–01) — one Supervising Investigator II, three Supervising Investigator Is, fifteen Senior Investigators, and ten investigator assistants and enforcement program clerical staff. In 2004, MBC's enforcement program staff consists of 20 fewer positions than it had in 1991–92, when it received 22% fewer complaints and took 75% fewer disciplinary actions. And the effects of the hiring freeze and budget cuts were not confined to MBC. HQE lost six DAG positions — all in its Los Angeles office, and OAH lost two ALJ positions.

The loss of its enforcement program positions required MBC to disband Operation Safe Medicine, a proactive strike unit created in January 2001 to target unlicensed and fraudulent medical practice in "back-room clinics" in low-income areas, and the Internet Crimes Specialist position intended to target misleading Web advertising, the prescribing of drugs without a prior good faith examination, and online narcotics trafficking.[89] The staffing cuts have required investigative supervisors to take on a partial caseload or other responsibilities in addition to their supervisorial duties. The Board lost an investigative supervisor position that designed and conducted training programs for investigators — so investigator training (other than required POST training) has for the most part ceased, and a senior investigator who had been assigned to HQE to provide trial support to HQE prosecutors approaching evidentiary hearings. The budget cuts have also forced the enforcement program to cut the hours of its district office medical consultants — who are needed to enable the Board to efficiently process quality of care cases; the decrease in MC hours is inconsistent with SB 1950's mandate that MBC focus on expediting quality of care cases in which patients have been injured. And although the freeze was lifted on July 1, 2004, its impacts continue.

[88] Legal issues surrounding the application of a hiring freeze, staffing cuts, and spending restrictions to a special-fund agency are untested and raise troubling policy issues.

[89] *See supra* Ch. IV.F.

MBC is required to reduce its expenditures by 5% in 2004–05 (for a total of almost $700,000); it is meeting that requirement through salary savings, by holding positions that become vacant open for three months before filling them.

Legislative attempts to ameliorate the impacts of the hiring freeze were thwarted during 2004. Senator Liz Figueroa introduced SB 1735, which would have lifted the hiring freeze on special-fund agencies, permitted them to reinstate abolished positions if funding is available, and prohibited the state from borrowing money from special-fund agencies. AB 1797 (Bermudez) would have declared that "the safety of California's patients is, in part, dependent on an effective and adequately staffed program that regulates the practice of physicians" and exempted the enforcement functions of MBC from the hiring freeze. Both bills died in committee.

Increased Costs of Doing Business. While MBC has been unable to fill vacant staff positions, it has been forced to incur higher costs in a number of areas — which explains why its overall expenditures have not significantly decreased with the loss of almost 45 positions. Without increased revenue, the Board has been forced to absorb a 5% salary increase for staff in July 2004, significant increases in workers' compensation premiums and employee benefits for its peace officer investigators, and an increase in the hourly rate paid to the Attorney General's Office. Additionally, SB 1950's addition of Business and Professions Code section 2220.08 — requiring the Board to implement a "specialty reviewer" requirement in the Central Complaint Unit — has meant additional costs to MBC that are discussed in Chapter VI below.

The Board recently submitted a budget change proposal (BCP) seeking to reinstate its 29 lost enforcement positions and at least four of the lost HQE positions; the BCP also included $1.3 million to cover the increased hourly rate charged by HQE, $970,000 to cover increased workers' compensation costs, an additional $450,000 for MBC's expert reviewer program (for both CCU and field office reviewers), and additional funding for the Board's district office medical consultants. On October 13, 2004, the Department of Finance rejected the BCP due to "insufficient fund reserves to support additional expenditures." MBC estimates that it will need a fee increase to $800 biennially to support the BCP. The proposed fee level is not inconsistent with the license fees charged by other comparable agencies; for example, the biennial renewal fee of the Board of Podiatric Medicine is $900 ($450 annually); the State Bar charged $390 in annual license fees during 2004 and is authorized to charge the same during 2005.[90] Fees have not increased for eleven years — accomplishing a 27.9% real spending reduction to 2004, as noted above. American Medical Association, California Medical Association, and local medical society membership dues total more than two times the annual bill for public protection.

[90] *See Assembly Floor Analysis of SB 1490 (Committee on Judiciary)* (June 25, 2004), Cal. Stats. 2004, c. 384.

3. MBC and HQE's management structure and information systems need improvement.

The Monitor has a number of concerns about various aspects of the management structure and management information systems of both MBC and HQE.

Medical Director Position. As discussed in Chapter IV, MBC abolished its "Chief Medical Consultant" (CMC) position in 1994 after a 16-month study that revealed confusion about the supervisorial hierarchy for the CMC and the district office medical consultants. The Board voted to create a more flexible position to be selected by and report to the Board's Executive Director. That position was not filled until July 2000, when MBC hired Dr. Neal Kohatsu, MD, MPH, as its new Medical Director. For three years, Dr. Kohatsu played an important role by assisting the Board and its staff in policy and program development, serving as a liaison to health care constituencies, and working with those constituencies to define issues of importance. While at MBC, he engaged in several important scientific studies with medical faculty at the University of California at San Francisco, including two published studies on characteristics that are potential predictors of physician discipline in California. Regrettably, Dr. Kohatsu left MBC in 2003 for a faculty position at the University of Iowa; because of the hiring freeze, MBC was unable to fill his position, and it was subsequently abolished. Reinstatement of the Medical Director position is a priority for MBC management, and the Monitor supports that effort.

Diversion Program Management. As required by SB 1950 (Figueroa), the Monitor has evaluated MBC's Diversion Program for substance-abusing physicians in Chapter XV below. One of the Monitor's key findings — as described more fully in that chapter — is that the management of the Diversion Program is not well-integrated into overall MBC management. For many years, the Medical Board — both the Board and its staff — has permitted Diversion to effectively function in a vacuum, separate not only from MBC enforcement management (as might be expected) but also from overall MBC management. As described in Chapter XV, this separation has resulted in a breakdown in key Diversion functions that poses a risk not only to the public but also to the physicians participating in the Program — and which breakdown was not communicated to MBC management. The Division of Medical Quality is statutorily required to oversee the Diversion Program,[91] and it reasonably delegates some of that responsibility to MBC management. However, management has not and cannot carry out that duty unless the administration of the Diversion Program is more fully integrated into MBC management.

Relationship between MBC and HQE. As described in Chapter IV above and Chapters VII and IX below, the Health Quality Enforcement (HQE) Section of the Attorney General's Office was created in SB 2375 (1990) to specialize in prosecuting physician and other health care

[91] Bus. & Prof. Code §§ 2346, 2352.1.

practitioner disciplinary matters. The statutes creating and delegating responsibility to HQE[92] do not merely create the section and require it to direct discipline-related MBC prosecutions. They also superimpose HQE over MBC complaint intake/processing and investigations by requiring the HQE Chief to "assign attorneys to assist [DMQ] in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . , to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."

As described above, MBC and HQE did not implement the "investigations" portion of SB 2375 until 1997, when it launched the Deputy in District Office (DIDO) program, under which HQE DAGs physically work in MBC district offices one or two days per week to provide assistance and guidance on investigative plans, identification of matters requiring immediate attention, and medical records procurement; DIDO DAGs also review all cases proposed for closure at the district office level, and (at least in southern California district offices) draft the initial pleading in cases being referred to HQE for filing. MBC and HQE did not formally implement the "intake" portion of SB 2375 until October 1, 2003; that effort is described in Chapter VI below.

As described more fully in Chapters VII and IX, the DIDO program — while certainly better than the prior situation in which investigators with no legal guidance worked up cases and handed them off to a prosecutor who had no input into the investigation and no post-handoff investigative assistance, and while very successful in lowering the average amount of time it takes HQE to file accusations in fully investigated cases — has proven unsatisfactory in many respects. Among other things, the DIDO program has created a strained relationship between MBC and HQE. MBC investigators we interviewed — when discussing their interactions with their investigative supervisor and the on-site DIDO DAG — universally expressed a "who's my boss?" confusion. This strained relationship becomes particularly acute when a trial DAG — the prosecutor who is going to represent the Board at the evidentiary hearing — needs additional investigative work after the case has been transmitted to and accepted by HQE. The existing "supplemental investigation" process requires supervising DAGs and supervising investigators to engage in a time-consuming and bureaucratic written request and negotiation process, which is inappropriate as a disciplinary matter nears evidentiary hearing. As noted below, the Monitor believes the "vertical prosecution" model first suggested in 1990 would resolve these problems and should be revisited.

Enforcement Policy/Procedure Manuals. MBC has a multitude of enforcement policy and procedural manuals. Unfortunately, most MBC manuals produced for us in late 2003 (and listed in Appendix C) had not been updated to reflect the many changes made by 2002's SB 1950 (Figueroa) and other important legislation. The Diversion Program Manual has not been updated since 1998

[92] Gov't Code § 12529 *et seq*.

and is effectively obsolete. No manual adequately and accurately addresses the role and function of the district office medical consultants, and the Medical Consultants' Reference Book has not been updated since 1996. Some MBC manuals contained inconsistencies, errors of fact, and/or errors of law that were identified in the Joint Legislative Sunset Review Committee's May 1, 2002 background paper[93] or by the Monitor[94]; those errors have since been corrected. Finally, HQE has no policy and procedure manual whatsoever. Because most HQE prosecutors are among the office's most senior attorneys, this may not pose a problem now; but when those senior attorneys retire over the next ten years, HQE will require a policy and procedure manual.

The existence of the Monitor position and the pendency of this Initial Report has prompted MBC enforcement staff in all quarters to revise and update many of its manuals. However, this function should be performed routinely and on a regular basis, and — especially in areas where legal interpretation is involved — with the consultation and approval of HQE.

Management Information Systems. The Monitor has numerous concerns about the management information systems of MBC, HQE, and the Diversion Program.

MBC is required to utilize the "Consumer Affairs System" (CAS), a mainframe computer program maintained by the Department of Consumer Affairs' Office of Information Services. CAS is so antiquated that the Department is reluctant to support further upgrades to it. Several attempts to replace it entirely have failed. Because CAS fails to meet its needs, MBC is forced to track some information manually or with additional small database programs.

CAS has limitations that impact the enforcement program. For example, CAS permits intake personnel to enter or "code" only limited information about incoming complaints. An alleged misdiagnosis or botched liposuction resulting in patient death must be coded as

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[93] In its May 1, 2002 background paper, JLSRC staff noted that, according to the *CCU Procedure Manual*, Business and Professions Code section 801 requires insurers to report payout information when "a malpractice settlement, judgment, or arbitration award of over $30,000 has been made" (which is an incorrect statement of law), while the *Enforcement Operations Manual* provides that an "arbitration award of any amount shall be reported to MBC" (which is correct). The CCU manual has been corrected.

JLSRC staff also found that the *Medical Consultant Procedure Manual* purported to interpret Business and Professions Code section 2234(c) ("repeated negligent acts") to require a showing of a "pattern" of departures from the standard of care. According to *Zabetian v. Medical Board* (2000) 80 Cal. App. 4th 462, 469, this interpretation is not correct because the Legislature expressly rejected the word "pattern" when considering the bill that originally added section 2234(c). That manual has been corrected.

[94] At a 2003 oral argument on a nonadoption, the Monitor was alerted to a repetition of the incorrect section 2234(c) interpretation (requiring a showing of a "pattern" of misconduct) in the *Individual Study Program for Expert Reviewers* (October 2002) when a defense attorney argued the necessity of a "pattern" and informed the DMQ panel that "your own procedure manual requires you to find a pattern" in order to discipline for repeated negligent acts. That error has been corrected.

"negligence/incompetence." Alleged prescribing of any medication — whether it is Vicodin, Viagra, or medical marijuana — without a good faith prior examination must be coded as "drug prescribing violation." This lack of detail inherent in the system has made it almost impossible for MBC to meaningfully respond to allegations of "profiling" or "selective prosecution" by various interest groups over the years — including CMA (which has alleged that MBC improperly targets "easy one-patient cases"), the alternative medicine community, and medical marijuana advocates. CAS does not have a "word search" capability enabling MBC (or the public) to systematically analyze its handling of any particular type of case.

CAS also limits the Board's ability to collect information about its handling of individual cases. Chapter VII describes MBC's recent institution of codes to capture the time spent by investigators in procuring medical records, scheduling subject physicians for interviews, and securing expert review of an investigative file. In the medical records area, the date records are requested is entered, and the date records are received is entered. While this may be sufficient in other areas, it is not sufficient for medical discipline matters. Investigators commonly seek medical records from four or five sources on any given patient, and more than one patient may be involved in a particular investigation — requiring the investigator to issue multiple requests for medical records to multiple physicians and facilities. The system will not accommodate this situation. The "records requested" date cannot be matched up with the "records received" date for each individual request — thus hindering MBC from accurately tracking the time it takes to procure medical records.

Finally, CAS affects MBC's public disclosure of information on its licensees. CAS data are largely "imported" onto the Board's Web site, so limitations on CAS' data fields result in limitations on the amount and type of information that MBC can disclose to the public via its Web site. For example, CAS' format does not have space to accommodate the entry of all significant terms and conditions of probation which are part of a public disciplinary order and would be important to a patient seeking a physician. The Board is working to address this issue, which is discussed more fully in Chapter XIII below.

The Diversion Program has its own in-house Diversion Tracking System (DTS), which is only three years old. DTS is supposed to contain a file on each participant which includes all information on the participant, the terms and conditions of his/her Diversion Program contract (including restrictions on medical practice), and his/her participation in the Diversion Program, including results of all bodily fluids testing (which are downloaded directly into DTS from the laboratory that tests participants' urine samples), absences from required group meetings, and dates of worksite monitor and therapist reports. As described in Chapter XV, DTS is used inconsistently by Diversion Program staff, resulting in the Program's inability to access all relevant information when it is most needed — when a participant has relapsed into drug/alcohol use and decisions about practice restrictions must be made very quickly to protect the public. In addition, we found inconsistencies between information found on DTS on a particular participant and information in

that participant's central file. We also found numerous errors and gaps in DTS which were unknown to Program staff, mostly stemming from the lab's download of incorrect urine testing information and DTS' failure to correctly post lab test information to the right participant's file. Diversion Program management believes that DTS is already obsolete, and has asked MBC's Information Systems Branch to design a new system.

For many years, the Attorney General's Office lacked an adequate management information system to capture adequate and accurate information on its processing and prosecution of disciplinary matters, including an itemized billing function that permitted its clients to know what they were paying for. Over the past decade, this issue arose frequently in the Legislature as occupational licensing agencies were increasingly being held accountable for their enforcement performance but were unable to obtain relevant information on the Attorney General's handling of their matters. In 2002, the Office finally implemented ProLaw, a relatively sophisticated case management system, in some of its units. ProLaw arrived at HQE in February 2004; all staff were trained in its use throughout the spring of 2004, and case management information has been tracked since July 2004. HQE management is comfortable with the case management aspect of the system, but has not had sufficient experience with other aspects of the system that enable it to generate usable reports on, for example, average time it takes from acceptance of a matter to the filing of the accusation (some of that kind of information is generated through other, non-ProLaw systems). As such, any evaluation of whether ProLaw has enabled HQE to better measure its performance and increase its accountability to its client agencies would be premature.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #1: Lost enforcement positions should be reinstated. MBC should resubmit its BCP to reinstate the 29 abolished enforcement positions and four HQE attorney positions, to enable the Board to rebuild its enforcement program, recreate Operation Safe Medicine and its Internet Crimes Unit, and expedite the processing of quality of care cases — the primary goal of SB 1950 (Figueroa).

Recommendation #2: Renewal fees should be increased. To support the additional expenses in the BCP, the statutory ceiling on the Board's biennial license renewal fee should be increased to $800 to cover inflation, the 29 reinstated enforcement positions and four HQE positions, additional funds for district office medical consultants who assist in the efficient processing of quality of care cases, the reinstatement of training programs for investigators and other enforcement program staff, additional funding for MBC's expert reviewer program (including the CCU "specialty reviewer" requirement in Business and Professions Code section 2220.08), and MBC's increased costs of doing business. This ceiling simply restores MBC's real, inflation-adjusted revenues to 1994 levels.

Recommendation #3: DCA and MBC must upgrade their management information systems. The Department of Consumer Affairs should continue its efforts to replace the CAS system with a system that integrates enforcement and licensing information, and accommodates more complete coding of complaints and reports to provide the Medical Board and its staff with relevant information about the substance of its caseload and the details of case aging and time consumed by each step of the process. MBC should continue its efforts to revise the Diversion Tracking System. In addition, HQE should fully implement ProLaw so it is used to its full capacity to increase HQE accountability to MBC and its other client agencies.

Recommendation #4: MBC should regularly update all enforcement manuals, and HQE should draft a policy and procedure manual. All MBC enforcement policy and procedure manuals should be regularly updated and reviewed by a team consisting of MBC management, legal counsel, and HQE representatives. The Diversion Program manual must be completely rewritten. HQE should draft a policy and procedure manual in anticipation of the impending retirement of many of its most senior prosecutors. This is an often-overlooked but important management function that must be recognized, resourced, and regularly performed.

In addition, the Monitor recommends that Diversion Program management be more fully integrated into overall MBC management, so as to enable the Division of Medical Quality and MBC management to accurately evaluate the performance of the Diversion Program Manager and staff and the Program itself. This recommendation is addressed in Chapter XV.

Finally, the Monitor believes that creation of a "vertical prosecution" model will produce higher-quality investigations and prosecutions of MBC disciplinary matters, and will serve to address the sometimes strained relationship between MBC and HQE. This recommendation is addressed in Chapters VII and IX.